

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

R. M. Lilley

FILED APR 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13259
STATE FILE NUMBER
1599
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 119 West 39 St. | | | Length of stay in lb 22 Yrs | | d. STREET ADDRESS (If outside, give location) 119 West 39 St. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Albert Middle Joseph Last Loucks | | | | 4. DATE OF DEATH Month April Day 5 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 28 1889 | | 9. AGE (In years last birthday) 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Holt County Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Franklin Loucks | | | | 14. MOTHER'S MAIDEN NAME Mary I. Kunkle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 496-16-0133 | | 17. INFORMANT Address Mrs Bonnie Loucks 119 West 39 St K.C.Mo. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-cerebral hemorrhage. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis | | | | | | 10 yrs. | |
| DUE TO (c) | | | | | | 33 1/2 | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> | | SUICIDE <input type="checkbox"/> | | HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Jan 3, 1957 to Apr 5-1957 and last saw her alive on 3-26-57 . Death occurred at about 7 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) R. M. Lilley, D.O. | | | | 22b. ADDRESS 3915 Main St Kansas City Mo | | 22c. DATE SIGNED 4-5-57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE April 5 1957 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) Mound City, Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS Mrs C.L. Forster Funeral Home Inc. K.c. No. | | | | 25. DATE RECD. BY LOCAL REG. 4-5-57 | | 26. REGISTRAR'S SIGNATURE Neal Minshall | |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John V. Herrick*.....

Licensed Embalmer No.

P. O. Address *J. L. ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

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